

CERTIFICATE OF DEATH

Reg. Dist. No.

9113

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>31 Aberdeen</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hartford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John Alfred Ames</u>		4. DATE OF DEATH <u>8-8-1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 26, 1934</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Balance</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>A.P.G.</u>	9. AGE (In years last birthday) <u>24</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel N. Ames</u>		14. MOTHER'S MAIDEN NAME <u>Elsie Willis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>213-30-5729</u>	
17. INFORMANT <u>Mrs. Victoria Ames - Aberdeen, Md.</u>		Address <u>44 Monroe St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>415X Congestive Heart Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Acute Rheumatic Myocarditis</u> DUE TO (c) <u>Gastroenteritis</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Gastroenteritis</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY a. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>July 29, 1958</u> , to <u>Aug. 8, 1958</u> , that I last saw the deceased alive on <u>Aug. 8, 1958</u> , and that death occurred at <u>3:25 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George J. Stansbury</u>		ADDRESS (Street, city or town, state) <u>529 Revolution St. Harre-de-Grace, Md.</u>	
PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u>		DATE SIGNED <u>8/11/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8-11-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Union Methodist Cem.</u>	22d. LOCATION (City, town, or county) <u>Aberdeen</u> (State) <u>MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. J. Sullord, Harre-de-Grace, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE AUG 13 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knott</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAYLAND STATE DEPARTMENT OF HEALTH—Baltimore, Md.

9114

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u>		c. LENGTH OF STAY IN 1b <u>14 1/2 hrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hartford Memorial Hospital</u>		d. STREET ADDRESS <u>409 Juniper St.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Austin Joshua Bennett</u>		4. DATE OF DEATH Month Day Year <u>August 4 1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APR. 21, 1897</u>
9. AGE (In years last birthday) <u>61</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician Contractor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>self</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Bennett</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Gray</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>747-09-2582</u>	
17. INFORMANT <u>Mrs. Blenda J. Bennett</u>		Address <u>Havre de Grace Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis cerebral</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>8/3/58</u> , 19 <u>58</u> , to <u>8/4/58</u> , 19 <u>58</u> that I last saw the deceased alive on <u>8/4/58</u> , 19 <u>58</u> , and that death occurred at <u>4:30 PM</u> , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <u>407 S. Union Ave</u>		DATE SIGNED <u>8/4/58</u>	
ACTUAL SIGNATURE <u>Wm. H. Wadsworth, M.D.</u>			
PHYSICIAN'S NAME (Type) <u>Wm. H. Wadsworth</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>8-7-1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ANGEL HILL</u>	22d. LOCATION (City, town, or county) (State) <u>HAVRE DE GRACE, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Madison McNeil</u>		ADDRESS <u>HAVRE DE GRACE, MD.</u>	
24a. REC'D BY REGISTRAR <u>Aug 7 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Wadsworth</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 18 Film 233 9-18-58 ams

CERTIFICATE OF DEATH

Reg. Dist. No.

09114

9115

1. PLACE OF DEATH o. COUNTY <u>Hartford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Hartford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Harre-de-Grace</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hartford Memorial Hospital</u>				d. STREET ADDRESS <u>RT. #2</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Everett Oscar Bradford</u>				4. DATE OF DEATH Month Day Year <u>8 2 1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/3/1883</u>	
9. AGE (In years last birthday) yrs. <u>75</u>		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant General Store</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>MD</u>			
11. BIRTHPLACE (State or foreign country) <u>MD</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Everett Bradford</u>				14. MOTHER'S MAIDEN NAME <u>Lena Heidline</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Address <u>Laura Bradford (wife) RT #2 Harre-de-Grace</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobar pneumonia - acute</u> DUE TO <u>Membranous Enterocolitis</u> DUE TO <u>Chronic Myocarditis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>490x Autopsy revealed: Acute amoebic dysentery; intestinal type</u>							
20a. CONTRIBUTING WAS UNDERLYING <input type="checkbox"/> OR ACCIDENTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month Day Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 5-58</u> , 19 <u>58</u> to <u>Aug 2</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>August 2</u> , 19 <u>58</u> , and that death occurred at <u>4:30</u> P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>O. L. Lewis MD</u>				ADDRESS (Street, city or town, state) <u>Harre-de-Grace MD</u>			
PHYSICIAN'S NAME (Type) <u>A. L. Lewis</u>				DATE SIGNED <u>8-6-58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/5/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Angel Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Hartford, MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Conroy</u>				24a. REC'D BY REGISTRAR <u>DATE AUG 8 '58</u>			
24b. REGISTRAR'S SIGNATURE <u>W. L. Lewis</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09115

Reg. Dist. No.

9136

1. PLACE OF DEATH o. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - STREET</u>		c. LENGTH OF STAY IN 1b <u>56 YRS.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>John W. BURKINS</u>		4. DATE OF DEATH Month Day Year <u>Aug. 12, 1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR. 13, 1902</u>
9. AGE (In years last birthday) <u>56</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RURAL LETTER CARRIER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. GOVT.</u>	
11. BIRTHPLACE (State or foreign country) <u>STREET, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES W. BURKINS</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET RIGDON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs. HILDA A. BURKINS</u>		Address <u>STREET, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 CORONARY OCCLUSION</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ATHEROSCLEROSIS</u> DUE TO (c) <u>PRE MYOCARDIAL INFARCTION 1955</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>PRE MYOCARDIAL INFARCTION 1955</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>26 Nov. 1957</u> to <u>12 Aug. 1958</u> , that I last saw the deceased alive on <u>10 Aug. 1958</u> , and that death occurred at <u>1 P. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Thos. A.E. Moseley, M.D.</u> <u>12 Aug 1958</u>			
ACTUAL SIGNATURE			
PHYSICIAN'S NAME (Type) <u>THOS. A.E. MOSELEY, JR</u> <u>JARRETTSVILLE, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8-15-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>EMORY</u>		22d. LOCATION (City, town, or county) (State) <u>STREET, HARFORD CO., MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Harkins</u>		ADDRESS <u>Delta, Pa.</u>	
24a. REC'D BY REGISTRAR <u>Aug 18 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanks</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

0220-51 804

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9137

CERTIFICATE OF DEATH

09116

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harve de Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harve de Grace</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>R. F. D. # 1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Georgiann</u> Middle <u>Cannon</u> Last <u>Cannon</u>		4. DATE OF DEATH Month <u>8</u> Day <u>30</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 2, 1870</u>
9. AGE (In years last birthday) <u>87</u> yrs.		10. IF UNDER 1 YEAR Months <u>10</u> Days <u>28</u> Hours <u></u> Min. <u></u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		12. BIRTHPLACE (State or foreign country) <u>Harford County, Md.</u>	
13. FATHER'S NAME <u>Joseph Collins</u>		14. MOTHER'S MAIDEN NAME <u>Sabina Gilbert</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs. Elva N. Johnson</u>		Address <u>Harve de Grace, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X Congestive Heart Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Hypertensive-Arteriosclerotic Heart Disease</u> DUE TO (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 10, 1956</u> , to <u>Aug. 30, 1958</u> , that I last saw the deceased alive on <u>Aug. 29, 1958</u> , and that death occurred at <u>8:10 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>M.D. 569 Revolution St. Harve de Grace, Md.</u> DATE SIGNED <u>8/30/58</u>			
ACTUAL SIGNATURE <u>George T. Stansbury</u>		PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-3-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Green Spring Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Green Spring, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Otelia J. Bullock</u>		ADDRESS <u>Harve de Grace, Md.</u>	
24a. REC'D BY REGISTRAR <u>REP 3 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

09117

9116

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Have de Grace</u>		c. LENGTH OF STAY IN 1b <u>4 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>31 Aberdeen,</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>				d. STREET ADDRESS <u>1 Edmund St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARGARET (Maggie) First Middle <u>Lena</u> COWSER COWSER				4. DATE OF DEATH Month <u>August</u> Day <u>18</u> Year <u>1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>20 Mar. 1896</u>		9. AGE (In years last birthday) yrs. <u>62</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Ned Harvy</u>				14. MOTHER'S MAIDEN NAME <u>Nellie -</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Fred Cowser - husband - same as above</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro Vascular Accident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>One week (7 days)</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u>Jan</u> Day <u>17</u> Year <u>1958</u> Hour o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JAN 17</u> , 19 <u>58</u> , to <u>Aug. 17</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Aug. 17</u> , 19 <u>58</u> , and that death occurred at <u>10:25 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>17 N. Phila. Blvd. Aberdeen Md.</u> DATE SIGNED <u>8/18/58</u>							
ACTUAL SIGNATURE <u>Andre Weiss</u> M.D.				PHYSICIAN'S NAME (Type) <u>ANDRE WEISS</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/21/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Thomas Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>St. Thomas, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Farring</u> ADDRESS <u>Aberdeen, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 21 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanks</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1116

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
JAMES H. HARRIS		M		45		1870	
PLACE OF BIRTH		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
BALTIMORE, MD.		LABORER		HEART DISEASE		NATURAL	
DATE OF DEATH		PLACE OF DEATH		DATE OF BURIAL		PLACE OF BURIAL	
1895		BALTIMORE, MD.		1895		BALTIMORE, MD.	
NAME OF FUNERAL HOME		NAME OF MINISTER		NAME OF CLERGYMAN		NAME OF CHURCH	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	
ADDRESS OF DECEASED		ADDRESS OF FUNERAL HOME		ADDRESS OF MINISTER		ADDRESS OF CLERGYMAN	
1234 BALTIMORE ST.		1234 BALTIMORE ST.		1234 BALTIMORE ST.		1234 BALTIMORE ST.	
CITY		CITY		CITY		CITY	
BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
STATE		STATE		STATE		STATE	
MD.		MD.		MD.		MD.	
COUNTRY		COUNTRY		COUNTRY		COUNTRY	
U.S.A.		U.S.A.		U.S.A.		U.S.A.	

THIS CERTIFICATE OF DEATH IS A PUBLIC DOCUMENT AND IS NOT TO BE USED FOR ANY OTHER PURPOSE THAN THAT FOR WHICH IT WAS ISSUED.

TO BE FILLED BY THE REGISTRAR OF DEATHS, BALTIMORE, MD.

1895

1

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09118

9138

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Harford</u>	
CITY OR TOWN <u>Rural, Bel Air</u>		LENGTH OF STAY (in this place) <u>3 years</u>		CITY OR TOWN <u>Bel Air</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Convalescent Home</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Carrie</u> (Middle) <u>Preston</u> (Last) <u>Cunningham</u>				(Month) <u>August</u> (Day) <u>22</u> (Year) <u>19 58</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>August 5, 1869</u>	9. AGE last birthday <u>89</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Jacob E. Bull</u>				14. MOTHER'S MAIDEN NAME <u>Mary Sunderland</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <u>✓</u>		17. INFORMANT & ADDRESS <u>Balto. 6, Md. Mrs. Mary L. Laird, 4106 Ashbury Ave.</u>			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
151X IMMEDIATE CAUSE (A) <u>Carcinoma of the stomach</u>				INTERVAL BETWEEN ONSET AND DEATH <u>18 months</u>			
ANTECEDENT CAUSE(S) DUE TO (B) _____							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) _____							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Toxic goiter</u>				<u>3 years</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March 19 48</u> , to <u>March 22</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>March 21</u> , 19 <u>58</u> , and that death occurred at <u>12:20 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Willard P. Hudson</u> M.D.				ADDRESS (Street, city, town, state) <u>Forest Hill, Maryland</u>		DATE SIGNED <u>August 22, 1958</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>August 25, '58</u>		NAME OF CEMETERY OR CREMATORY <u>Rock Spring Episcopal</u>		LOCATION (City, town, or county) (State) <u>Forest Hill, Maryland</u>	
24. REC'D BY REGISTRAR <u>AUG 26 '58</u>		REGISTRAR'S SIGNATURE <u>Charles E. Kraus</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Foster</u>		ADDRESS <u>Bel Air Md</u>	

9117

CERTIFICATE OF DEATH

09119

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVRE DE GRACE</u>		c. LENGTH OF STAY IN 1b <u>36 HRS.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL HOSP.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Baby Girl Fields</u>		4. DATE OF DEATH Month <u>August</u> Day <u>5</u> Year <u>1958</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>COLORED</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>8-3-58</u>
9. AGE (In years last birthday) yrs. <u>1</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NEWBORN</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Anthony Ambrose Fields</u>		14. MOTHER'S MARDEN NAME <u>Marion Louise Boddy</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Premature - Atelofosis</u> <u>762.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs.</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>o. m.</u> <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>8-3</u> , 19 <u>58</u> , to <u>8-5</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>8-4</u> , 19 <u>58</u> , and that death occurred at <u>12:45</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u>		DATE SIGNED <u>Aug 8 1958</u>	
PHYSICIAN'S NAME (Type) _____			
22a. REMOVAL <input type="checkbox"/> CREMATION <input type="checkbox"/> (Specify)	22b. DATE THEREOF <u>8-5-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>HARFORD MEMORIAL HOSPITAL</u>	22d. LOCATION (City, town, or county) _____ (State) _____
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry R. Zilly</u>		24a. REC'D BY REGISTRAR DATE <u>Aug 8 '58</u>	24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and is completely filled in by the funeral director; page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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9118

CERTIFICATE OF DEATH

09120

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>24 Havre de Grace</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Harford Memorial Hospital</u>		d. STREET ADDRESS <u>General Delivery</u>	
3. NAME OF DECEASED (Type or print) First <u>Arthur</u> Middle <u>Finkernagel</u> Last <u>Finkernagel</u>		4. DATE OF DEATH Month <u>August</u> Day <u>20</u> Year <u>1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>20 April 1886</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RR employee</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad Brake-man (Ret)</u>	9. AGE (In years last birthday) yrs. <u>72</u>
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Finkernagel</u>		14. MOTHER'S MAIDEN NAME <u>Annie Oals</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-12-0876</u>	
17. INFORMANT <u>Frances Preston</u> sister		Address <u>423 Roberts Way, Aberdeen, Md.</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema, Bronchopneumonia, Azotemia</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>8-9</u> , 19 <u>58</u> , to <u>8-20</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>8-20</u> , 19 <u>58</u> , and that death occurred at <u>12-59</u> M, from the causes and on the date stated above.		
ADDRESS (Street, city or town, state) <u>608 So. Union Ave. Havre de Grace, Md.</u>		DATE SIGNED <u>20 August 1958</u>
ACTUAL SIGNATURE <u>Frank D. Hauber</u>		
PHYSICIAN'S NAME (Type) <u>Frank D. Hauber M.D.</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/23/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Angel Hill</u>
22d. LOCATION (City, town, or county) (State) <u>Havre de Grace, Maryland</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Tarring</u>		24a. REC'D BY REGISTRAR <u>Aug 25 58</u>
ADDRESS <u>Aberdeen, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Evans</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and is completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9119

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Hartford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Hartford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Aberdeen</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hartford Memorial Hosp. (DOA)</u>				1d. STREET ADDRESS <u>RD #2</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Charles W. Glassman Sr.</u>		First Middle Last		4. DATE OF DEATH Month <u>August</u> Day <u>5</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>23 July 1888</u>	9. AGE (In years lost birthday) yrs. <u>70</u>	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>State Rd. Comm.</u>		11. BIRTHPLACE (State or foreign country) <u>Churchville, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>John Glassman</u>				14. MOTHER'S MAIDEN NAME <u>Marie Whitne</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>W.W. #1 220-36-8622</u>		17. INFORMANT <u>Charles W. Glassman Jr.</u>		Address <u>R.D. 1 Aberdeen, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute Pulmonary Oedema</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerotic C-V Disease</u> DUE TO (c) <u>8 yrs</u>						INTERVAL BETWEEN ONSET AND DEATH <u>chronic</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u>19</u> Day <u>19</u> Year <u>1958</u> Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 1, 1958</u> to <u>Aug 5, 1958</u> , that I last saw the deceased alive on <u>Aug 3, 1958</u> , and that death occurred at <u>3:00 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. Ralph Horky</u> M.D.				ADDRESS (street, city or town, state) <u>Churchville</u> DATE SIGNED <u>Aug 5</u>			
PHYSICIAN'S NAME (Type) <u>J. Ralph Horky</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/8/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Presbyterian Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Churchville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John B. Lanning</u>				ADDRESS <u>Aberdeen, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 8 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and is completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9139 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09122

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Street</u>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Street</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>R17</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Ernest</u> Middle <u>Hall</u> Last <u>Hall</u>		4. DATE OF DEATH Month <u>August</u> Day <u>23</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 6, 1902</u> 56 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>	
11. BIRTHPLACE (State or foreign country) <u>Wilkes Co., M.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Amos Hall</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Asher</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>239-09-4539</u>	
17. INFORMANT <u>Mr. Clay Hall</u>		Address <u>Street Harford MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GSW Cerubrum</u> <u>976X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Shot self with pistol</u>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot self with pistol</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>8-23-58</u> p.m. <u>10</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>Street Harford MD</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> <u>MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>Aug 25, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Elkridge Co., MD</u>		22d. LOCATION (City, town, or county) (State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H S Bailey</u>		24. REC'D BY REGISTRAR <u>Aug 26 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>			

MD153

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

0133 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT



Form with multiple sections for medical examination and death certification, including checkboxes and lines for text entry.

1. Name of Deceased: _____

2. Date of Death: _____

3. Place of Death: _____

4. Cause of Death: _____

5. Manner of Death: _____

6. Signature of Medical Examiner: _____

7. Date of Examination: _____

8. Hospital or Clinic: _____

9. Physician: _____

10. Coroner: _____

11. Burial Place: _____

12. Other: _____

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMG. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9140 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09123

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CARDIFF</u>		c. LENGTH OF STAY IN 1b <u>58 YRS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>MAIN ST</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ROBERT WARREN HARVEY</u>		4. DATE OF DEATH <u>AUGUST 26 19 58</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC 29 18 99</u>
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MECHANIC</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MACHINES</u>	
11. BIRTHPLACE (State or foreign country) <u>CARDIFF, MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES ALEXANDER HARVEY</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH R. JONES</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> <u>WWII</u> (If yes, give year or dates of service) <u>008-07-8615</u>		16. SOCIAL SECURITY NO. <u>008-07-8615</u>	
17. INFORMANT <u>HOWARD HARVEY</u> Address <u>(SAME)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 ACUTE CORONARY THROMBOSIS</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>INSTANT</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour <u>o. m.</u> <u>p. m.</u> <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Philip W. Heuman</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>PHILIP W. HEUMAN</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8-29-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>SLATE RIDGE</u>		22d. LOCATION (City, town, or county) <u>DELTA, PA.</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Habins, Delta, Pa.</u>		24a. REC'D BY REGISTRAR <u>AUG 29 58</u>	
		24b. REGISTRAR'S SIGNATURE _____	

Orthman 8-2-58

09124

9120

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Harford</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) o. STATE <i>Md.</i> b. COUNTY <i>Harford</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Havre de Grace</i>		c. LENGTH OF STAY IN 1b <i>33 minutes</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>24 Havre de Grace</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Harford Memorial Hospital</i>				d. STREET ADDRESS <i>1 1130 Union Ave.</i>		e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Sam</i> Middle <i>AN</i> Last <i>Hill</i>				4. DATE OF DEATH Month <i>Aug.</i> Day <i>22</i> Year <i>1958</i>			
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3/24/1898</i>	9. AGE (In years last birthday) <i>60</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Chatham Spring</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CRIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Scott Hill</i>		14. MOTHER'S MAIDEN NAME <i>Anne Chace</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Unknown</i>		16. SOCIAL SECURITY NO. <i>Unknown</i>		17. INFORMANT <i>Elizabeth Hill (wife)</i>		Address <i>Same.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Anger</i> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <i>1 hour</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>July 1957</i> to <i>August 22, 1958</i> , that I last saw the deceased alive on <i>August 22, 1958</i> , and that death occurred at <i>1:59 P.M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Edward J. Simon</i> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <i>Havre de Grace, Md.</i>			
PHYSICIAN'S NAME (Type) <i>EDWARD J. SIMON</i>				<i>Havre de Grace, Md.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <i>8/25/58</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Mt. Eain</i>		22d. LOCATION (City, town, or county) (State) <i>Havre de Grace, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Conington S. Hance</i>				ADDRESS <i>Havre de Grace, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>AUG 26 '58</i>	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hance</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and is to be used for the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

0012

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 45		4. RACE White		5. DATE OF DEATH Jan 15 1918		6. PLACE OF DEATH Home	
7. CITY OR TOWN WHERE DECEASED Baltimore		8. COUNTY Baltimore		9. STATE Maryland		10. MARITAL STATUS Married		11. OCCUPATION Clerk		12. CAUSE OF DEATH Pneumonia	
13. DATE OF BIRTH Jan 15 1873		14. PLACE OF BIRTH Baltimore		15. MOTHER'S NAME Mary H. Harris		16. FATHER'S NAME John H. Harris		17. PREVIOUS ILLNESS None		18. MEDICAL ATTENDANCE Yes	
19. NAME OF PHYSICIAN Dr. J. H. Harris		20. NAME OF FUNERAL HOME None		21. NAME OF BURIAL PLACE None		22. NAME OF CEMETERY None		23. NAME OF INTERMENT None		24. NAME OF INTERMENT None	
25. NAME OF DECEASED JAMES H. HARRIS		26. SEX Male		27. AGE 45		28. RACE White		29. DATE OF DEATH Jan 15 1918		30. PLACE OF DEATH Home	
31. CITY OR TOWN WHERE DECEASED Baltimore		32. COUNTY Baltimore		33. STATE Maryland		34. MARITAL STATUS Married		35. OCCUPATION Clerk		36. CAUSE OF DEATH Pneumonia	
37. DATE OF BIRTH Jan 15 1873		38. PLACE OF BIRTH Baltimore		39. MOTHER'S NAME Mary H. Harris		40. FATHER'S NAME John H. Harris		41. PREVIOUS ILLNESS None		42. MEDICAL ATTENDANCE Yes	
43. NAME OF PHYSICIAN Dr. J. H. Harris		44. NAME OF FUNERAL HOME None		45. NAME OF BURIAL PLACE None		46. NAME OF CEMETERY None		47. NAME OF INTERMENT None		48. NAME OF INTERMENT None	

u.s.

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH AND IS NOT VALID FOR THE PURPOSES OF THE FEDERAL GOVERNMENT.

1 **FOR STATE HEALTH DEPT.**

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09125

Reg. Dist. No.

9141

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyde R.D.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyde R.D.</u>	
c. LENGTH OF STAY IN lb <u>Lifetime</u>		d. STREET ADDRESS <u>Reckord</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Joseph Ruby Hooper</u>		4. DATE OF DEATH <u>August 17 1955</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 9 1891</u>
9. AGE (In years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>County Roads</u>	
11. BIRTHPLACE (State or foreign country) <u>Redford, Maryland.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Columbus Hooper</u>		14. MOTHER'S MAIDEN NAME <u>Mary Orem</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>W.W. 1</u>		16. SOCIAL SECURITY NO. <u>213-26-0426</u>	
17. INFORMANT <u>Clarence Hooper,</u>		Address <u>Reckord Maryland.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive CV disease</u> <u>443x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, md</u> DATE SIGNED <u>8-18-55</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Aug. 21, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Maryland.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard K. McKenna Jr</u>		24a. REC'D BY REGISTRAR <u>Abingdon Md.</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO STATE
THE COUNTY

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

[Faint, mostly illegible text and markings on the form, including what appears to be a signature and various administrative stamps.]

[Vertical text on the right margin, likely a filing or processing stamp, mostly illegible.]

9142

CERTIFICATE OF DEATH

09126

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD. b. COUNTY HARFORD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WHITEFORD				c. LENGTH OF STAY IN TB 86 YRS.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last BENJAMIN HIRAM JONES				4. DATE OF DEATH Month Day Year AUG. 22, 1958			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 11, 1872	
9. AGE (In years) 85		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FOREMAN - HIGHWAY DEPT.		11. BIRTHPLACE (State or foreign country) WHITEFORD, MD.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME HIRAM JONES		14. MOTHER'S MAIDEN NAME SARA JANE NORRIS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-18-729		17. INFORMANT Address WARFIELD JONES, WHITEFORD, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO 332 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Ant. Scler. Cerebro-Vasculal Disease DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1940 to Aug 22, 1958 , that I last saw the deceased alive on Aug 21, 1958 , and that death occurred at 6:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Delta Pa DATE SIGNED Aug 25 '58							
ACTUAL SIGNATURE John A. Hunt M.D.				PHYSICIAN'S NAME (Type) John A. Hunt			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8-25-58		22c. NAME OF CEMETERY OR CREMATORY SLATE RIDGE		22d. LOCATION (City, town, or county) (State) DELTA, PA.	
23. FUNERAL DIRECTOR'S SIGNATURE John A. Haskins, DELTA, PA ADDRESS				24a. REC'D BY REGISTRAR AUG 26 '58		24b. REGISTRAR'S SIGNATURE William E. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and is completely filled in by the funeral director. Page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2142

NAME OF DECEASED <i>James Louis</i>		SEX <i>Male</i>		AGE <i>40</i>	
DATE OF DEATH <i>April 10, 1912</i>		PLACE OF DEATH <i>Home</i>		CITY <i>Baltimore</i>	
CAUSE OF DEATH <i>Heart failure</i>		DISEASE OR INJURY <i>Myocarditis</i>		MEDICAL HISTORY <i>None</i>	
SIGNATURE OF PHYSICIAN <i>Wm. H. ...</i>		SIGNATURE OF CLERK <i>...</i>		SIGNATURE OF DECEASED <i>...</i>	
DATE OF SIGNATURE <i>April 10, 1912</i>		PLACE OF SIGNATURE <i>...</i>		CITY <i>Baltimore</i>	
NAME OF DECEASED <i>James Louis</i>		SEX <i>Male</i>		AGE <i>40</i>	
DATE OF DEATH <i>April 10, 1912</i>		PLACE OF DEATH <i>Home</i>		CITY <i>Baltimore</i>	
CAUSE OF DEATH <i>Heart failure</i>		DISEASE OR INJURY <i>Myocarditis</i>		MEDICAL HISTORY <i>None</i>	
SIGNATURE OF PHYSICIAN <i>Wm. H. ...</i>		SIGNATURE OF CLERK <i>...</i>		SIGNATURE OF DECEASED <i>...</i>	
DATE OF SIGNATURE <i>April 10, 1912</i>		PLACE OF SIGNATURE <i>...</i>		CITY <i>Baltimore</i>	



1. The death certificate is a legal document which must be filled out by a physician or other qualified person. It is used to determine the cause of death and to provide information for the funeral home and the state department of health.

2. The death certificate is a legal document which must be filled out by a physician or other qualified person. It is used to determine the cause of death and to provide information for the funeral home and the state department of health.

3. The death certificate is a legal document which must be filled out by a physician or other qualified person. It is used to determine the cause of death and to provide information for the funeral home and the state department of health.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and is completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09127

9121

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre De Grace		c. LENGTH OF STAY IN 1b 36 hrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Memorial hospital		d. STREET ADDRESS Rising Sun 07X-2	
3. NAME OF DECEASED (Type or print) First Elsie Middle Mary Last Keilholtz		4. DATE OF DEATH Month Aug. Day 31 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 8, 1898
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Rising Sun, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Harvey K. Garvin		14. MOTHER'S MAIDEN NAME Mary Ewing	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Clyde Keilholtz		Address Rising Sun, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 days 5 yrs.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/28 , 19 58 , to 8/31 , 19 58 , that I last saw the deceased alive on 8/31 , 19 58 , and that death occurred at 10A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Neil Taylor		ADDRESS (Street, city or town, state) Rising Sun, Md	
PHYSICIAN'S NAME (Type) Neil Taylor		DATE SIGNED 9/1/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 3, 1958	
22c. NAME OF CEMETERY OR CREMATORY Brookview Cem.		22d. LOCATION (City, town, or county) (State) Rising Sun Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Earl Jenson		ADDRESS Rising Sun, Md.	
24a. REC'D BY REGISTRAR DATE SEP 3 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	

9143

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen 31	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION US Army Hospital, APG, Md.		d. STREET ADDRESS 125 Osborne Road	
3. NAME OF DECEASED (Type or print) First SHEALA Middle LAY Last LAY		4. DATE OF DEATH Month August Day 8 Year 1958	
5. SEX Female	6. COLOR OR RACE Cau	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7 August 1958
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NA		10b. KIND OF BUSINESS OR INDUSTRY NA	
13. FATHER'S NAME CURTIS WAYNE LAY		14. MOTHER'S MAIDEN NAME Elisabeth Seiberth	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Father		Address 125 Osborne Road Aberdeen, Md.	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Distress 762.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Possible aspiration after birth DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 24 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7 August , 19 58 , to 8 August , 19 58 , that I last saw the deceased alive on 8 August , 19 58 , and that death occurred at 6:00 AM , from the causes and on the date stated above.	
ACTUAL SIGNATURE John Z. Delp	DATE SIGNED 8 August 1958
PHYSICIAN'S NAME (Type) JOHN Z DELP CAPT MC USAH, APG, Md.	

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug 11th 1958	22c. NAME OF CEMETERY OR CREMATORY Post Cemetery	22d. LOCATION (City, town, or county) (State) Aberdeen Proving Ground, Md.
23. FUNERAL DIRECTOR'S SIGNATURE John E. Sabing		ADDRESS Aberdeen, Md.	24a. REC'D BY REGISTRAR AUG 12 1958
			24b. REGISTRAR'S SIGNATURE Arthur L. Kraus

2050222XV6

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon #4. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		RELIGION	
JAMES H. HARRIS		45		M		W		C	
RESIDENCE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH	
1234 E. BALTIMORE ST.		JAN 10 1921		HOME		HEART DISEASE		NATURAL	
OCCUPATION		EDUCATION		MARRIAGE		PREVIOUS ILLNESS		HISTORY	
CLOCK REPAIRER		8 YEARS		MARRIED		NONE		NONE	
BIRTH		DATE OF BIRTH		PLACE OF BIRTH		MOTHER'S NAME		FATHER'S NAME	
BALTIMORE, MD.		JAN 15 1876		BALTIMORE, MD.		JANE HARRIS		JOHN HARRIS	
DATE OF INTERMENT		PLACE OF INTERMENT		NAME OF MINISTER		NAME OF CHURCH		NAME OF FUNERAL HOME	
JAN 12 1921		CATHOLIC CHURCH		FATHER		ST. ANNE'S CHURCH		JOHN J. HARRIS	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES		SIGNATURE OF MINISTER		SIGNATURE OF FUNERAL HOME		SIGNATURE OF REGISTRAR	
DATE OF REGISTRATION		PLACE OF REGISTRATION		NAME OF REGISTRAR		NAME OF CLERK		NAME OF ASSISTANT	
JAN 10 1921		BALTIMORE, MD.		JOHN J. HARRIS		JANE HARRIS		JOHN HARRIS	

RECEIVED
BALTIMORE, MD.
JAN 10 1921

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09129

9144

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY HARFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rocks		c. LENGTH OF STAY IN lb 3 yrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Woods near Rocks State Park		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle RALPH Last LOGAN		4. DATE OF DEATH Month August Day 29 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 6-1906 58 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY DAY	
11. BIRTHPLACE (State or foreign country) Belair Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Lagan		14. MOTHER'S MAIDEN NAME Sarah Ann Terry	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-07-8922	
17. INFORMANT Mrs Eugene Everett		Address Rocks Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Undetermined. 795.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , <u>Undetermined manner</u> <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE William V. Lovitt, Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF Sept 2-58	22c. NAME OF CEMETERY OR CREMATORY Friend Ship	22d. LOCATION (City, town, or county) (State) Fallston Harford Md
23. FUNERAL DIRECTOR'S SIGNATURE William V. Lovitt, Jr.		ADDRESS Janetsoville	
24a. REC'D BY REGISTRAR SEP 3 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

9145

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, putting the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>NORTH CAROLINA</u> b. COUNTY <u>Burke</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EDGEWOOD (RURAL)</u>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HICKORY</u>	<input checked="" type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WINTERS RUN 1/4 MILE WEST ST. RD #7</u>		d. STREET ADDRESS <u>Rt #4</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>HERMAN PRESSLY LYNN</u>	First Middle Last	4. DATE OF DEATH <u>AUGUST 9 1958</u>	Month Day Year
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 5, 1929</u>
9. AGE (In years last birthday) <u>29</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machine Operator</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Fabric</u>	11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Samuel Lynn</u>		14. MOTHER'S MAIDEN NAME <u>Hazel Martha Kiser, Hickory, N.C.,</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>	16. SOCIAL SECURITY NO. <u>Korean 242-52-3324</u>	17. INFORMANT <u>Hazel Willis Lynn, Hickory, N.C.,</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ASPHYXIAATION</u> 929.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>DROWNING</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 MIN</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year <u>11:45 a.m. AUG 9 1958</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>STREAM</u>	20f. (City or town) (County) (State) <u>HANBIBBER, HARFORD, MD</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Philip W. Heuman</u>	CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>AUG 9, 1958</u>
EXAMINER'S NAME (Type) <u>PHILIP W. HEUMAN</u>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	22b. DATE THEREOF <u>Aug. 10 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Kirksey Funeral Home</u>	22d. LOCATION (City, town, or county) (State) <u>Morganton, Burke, N.C.,</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard L. McCornick Jr</u>		ADDRESS <u>Abingdon, Maryland.</u>	24a. REC'D BY REGISTRAR DATE <u>AUG 13 '58</u>
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

0115

WEST VIRGINIA STATE DEPARTMENT OF HEALTH - BALTIMORE 25
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0115

WEST VIRGINIA STATE DEPARTMENT OF HEALTH



1. Cause of Death: ☐ Natural ☐ Accidental ☐ Suicide ☐ Homicide ☐ Undetermined

2. Manner of Death: ☐ Natural ☐ Accidental ☐ Suicide ☐ Homicide ☐ Undetermined

3. Place of Death: ☐ Home ☐ Hospital ☐ Prison ☐ Other

4. Date of Death: _____

5. Time of Death: _____

6. Signature of Medical Examiner: _____

7. Signature of Coroner: _____

9122

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Hartford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u>				c. LENGTH OF STAY IN <u>2 mos. 3 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hartford Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Minnie</u> Middle <u>AA</u> Last <u>Meyers</u>				4. DATE OF DEATH Month <u>August</u> Day <u>21</u> Year <u>1958</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>DEC. 8, 1874</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months <u>30</u> Days <u>12</u> Hours <u>0</u> Min.		IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
				11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, Md</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>CHARLES MEYERS</u>				14. MOTHER'S MAIDEN NAME <u>WILHELMINIA SCHROEDER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
				17. INFORMANT (sister) Address <u>Elizabeth Stone, 1400 W. Lexington St. Balti.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Degenerative R. Leg</u> DUE TO (c) <u>Advanced ASCVD Disease & debilities</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Alcohol of the spine and back</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>30 days</u> <u>2 1/2 mos.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>June 18, 1958</u> , to <u>Aug 21, 1958</u> , that I last saw the deceased alive on <u>Aug 21, 1958</u> , and that death occurred at <u>4:10 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. H. Sadowsky</u> M.D.				ADDRESS (Street, city or town, state) <u>600 S. Union St., Haverhill, Mass.</u>			
DATE SIGNED <u>8/21/58</u>							
PHYSICIAN'S NAME (Type) <u>W H SADOWSKY MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>AUG. 25, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>OAK LAWN</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE Co. Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook & Son</u> ADDRESS <u>1217 ST. PAUL ST.</u>				24a. REC'D BY REGISTRAR <u>DATE AUG 25 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician or the funeral director. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9146

CERTIFICATE OF DEATH

09132

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen			c. LENGTH OF STAY IN 1b 31 Aberdeen		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Paradise Road			d. STREET ADDRESS Paradise Road		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Betty Trout Motsinger			4. DATE OF DEATH August 21 19 58		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4 Oct. 1869		9. AGE (In years last birthday) 88 yrs.
			IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? USA.					
13. FATHER'S NAME Jacob Miller Trout			14. MOTHER'S MAIDEN NAME Mary Magdalene Etzler		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. ** **		17. INFORMANT A.V. Motsinger Address Paradise Rd. Aberdeen, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 450.0 IMMEDIATE CAUSE (a) Generalized circulatory failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pneumonia, hypostatic, rt. lung (c) Generalized arteriosclerosis					INTERVAL BETWEEN ONSET AND DEATH 1 wk 2 yr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from 1951 to 8-21-58 , that I last saw the deceased alive on 8-21-58 , and that death occurred at 6:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 8 Law Street DATE SIGNED 8-22-58					
ACTUAL SIGNATURE Peter P. Rodman M.D.					
PHYSICIAN'S NAME (Type) Peter P. Rodman, M.D.		Aberdeen, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 8/23/58		22c. NAME OF CEMETERY OR CREMATORY Mitchell Cemetery	
22d. LOCATION (City, town, or county) Mitchell, Indiana					
23. FUNERAL DIRECTOR'S SIGNATURE John G. Tarring		ADDRESS Aberdeen, Md.		24a. REC'D BY REGISTRAR AUG 26 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09133

9123

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>				c. LENGTH OF STAY IN 1b <u>Lifetime</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>None</u>				d. STREET ADDRESS <u>109 N. Union</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Bertie May Myers</u> First Middle Last				4. DATE OF DEATH <u>8/12/58</u> Month Day Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 19-1888</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>			
11. BIRTHPLACE (State or foreign country) <u>Cambridge, Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Levin Walter Robinson</u>				14. MOTHER'S MAIDEN NAME <u>Alice Barwick</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Unknown</u>			
17. INFORMANT <u>Walter Robinson</u> Address <u>109 N. Union Ave</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio Sclerosis</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>8/12/58</u> to <u>8/15/58</u> that I last saw the deceased alive on <u>8/12/58</u> , 19 <u>58</u> , and that death occurred of <u>N.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A. L. Lewis</u> M.D.				DATE SIGNED <u>8-15-58</u>			
PHYSICIAN'S NAME (Type) <u>A. L. Lewis</u>				ADDRESS (Street, city or town, state) <u>Harford, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/15/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Angel Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Harford, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William D. ...</u> ADDRESS <u>Harford, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 19 '58</u>		24b. REGISTRAR'S SIGNATURE <u>William D. ...</u>	

03153

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

1933

FILED
JAN 10 1934
BALTIMORE, MD

[Faint, mostly illegible text and markings on the certificate form, including fields for name, date, and cause of death.]

9124

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>32 Del Air</u>			
c. LENGTH OF STAY IN 1b <u>18 hrs.</u>				d. STREET ADDRESS <u>Webster St.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD Memorial</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Anne</u> First <u>Fredricka</u> Middle <u>Noonan</u> Last				4. DATE OF DEATH <u>August 29</u> 19 <u>58</u> Month Day Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 9, 1906</u>	
9. AGE (In years last birthday) <u>52</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supervisor</u>		11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Fred Morlok</u>				14. MOTHER'S MAIDEN NAME <u>Rosa De Martin</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>212-38-2520</u>		17. INFORMANT <u>Mrs. Rosa Morlok, Aberdeen, Maryland.</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>DIFFUSE PERITONITIS</u> <u>572.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>RUPTURE DIVERTICULUM SIGMOID COLON</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>August 29</u> , 19 <u>58</u> , to <u>12th</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>August 29</u> , 19 <u>58</u> , and that death occurred at <u>12th</u> P.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Frank D. Hauber</u>				ADDRESS (Street, city or town, state) <u>608 So. Union Ave., Havre de Grace, Md.</u> DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>Frank D. Hauber</u>				<u>608 So., Union Ave., Havre de Grace, Md.,</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 1, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Paul's Lutheran</u>		22d. LOCATION (City, town, or county) (State) <u>Aberdeen R.D., Harford, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard K. McCormack</u> ADDRESS <u>Abingdon, Md.</u>				24a. REC'D BY REGISTRAR <u>SEP 3 '58</u> DATE		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy and return to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9125

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE</u>				c. LENGTH OF STAY IN 1b <u>17 1/2 DAYS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL HOSP.</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE</u>			
d. STREET ADDRESS <u>1329 Wilson St.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>ETHEL</u> Last <u>POWELL</u>				4. DATE OF DEATH Month <u>August</u> Day <u>2</u> Year <u>1958</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 1, 1894</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Mississippi</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Andrew Jackson Landrum</u>				14. MOTHER'S MAIDEN NAME <u>Anna Mariah Tisdale</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Mary Ethel Graham, Harford Grace, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> DUE TO <u>Chr. Hypertensive Cardio-Vasc. Disease?</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Chr. Hypertensive Cardio-Vasc. Disease?</u> (c) <u></u>				INTERVAL BETWEEN ONSET AND DEATH <u>9/15/58</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>July 15, 1958</u> , to <u>Aug 2, 1958</u> , that I last saw the deceased alive on <u>Aug 15, 1958</u> , and that death occurred at <u>4:35 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William P. Hudson</u>				ADDRESS (Street, city or town, state) <u>Forest Hill, Md</u>			
PHYSICIAN'S NAME (Type) <u>W. Madison Mitchell</u>				DATE SIGNED <u>8/2/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8-4-1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ANGEL HILL</u>		22d. LOCATION (City, town, or county) (State) <u>HAURE DE GRACE MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Madison Mitchell</u>				ADDRESS <u>Harford Grace Md.</u>		24a. REC'D BY REGISTRAR <u>AUG 5 1958</u>	
24b. REGISTRAR'S SIGNATURE <u>W. Madison Mitchell</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: For use as the burial-transit permit. This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9147 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 7 Film 233 8-29-58 et

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>PARADISE R.D. #2</u>		d. STREET ADDRESS <u>R.D. #2</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Grover C. Preston</u>	4. DATE OF DEATH <u>August 20 1958</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 28 1885</u> 73 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Saw-Mill Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Saw-Mill</u>	10c. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>Benjamin V. Preston</u>		14. MOTHER'S MAIDEN NAME <u>Julia Lay</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-12-4085</u>	17. INFORMANT <u>Mrs. Grover C. Preston</u> Address <u>R.D. #2 Aberdeen, Md.</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH _____
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air</u> DATE SIGNED <u>8-21-58</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> <u>Md.</u>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/24/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rock Run Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>RD. Havre de Grace, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Farring</u> ADDRESS <u>Aberdeen, Md.</u>		24a. REC'D BY REGISTRAR <u>AUG 25 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraw</u>

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health.

11/15/95 11:15 AM

9126

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BEL AIR</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>32 BEL AIR</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>ROCKS SPRING (NO. MAIN ST)</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARGARET</u> Middle <u>ELLEN</u> Last <u>SHANAHAN</u>		4. DATE OF DEATH Month <u>AUGUST</u> Day <u>2</u> Year <u>19 58</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 7, 1885</u>
9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housekeeper</u>	
11. BIRTHPLACE (State or foreign country) <u>Rocks, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Cornelius Murphy</u>		14. MOTHER'S MAIDEN NAME <u>Deborah Sullivan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Cornelia L. Murphy</u>		Address <u>423 Montland AVE BEL AIR, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIO SCLEROTIC HYPERTENSIVE DISEASE</u> (c) <u>CARDIO-VASCULAR DISEASE</u> INTERVAL BETWEEN ONSET AND DEATH <u>UNDER 1 HR</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Philip W. Heuman</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>PHILIP W. HEUMAN</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>August 5, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>BEL AIR Memorial Gardens</u>		22d. LOCATION (City, town, or county) (State) <u>BEL AIR, Harford Co., Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph W. Foster</u>		ADDRESS <u>Broadway + Will Pams. St. BEL AIR, Maryland</u>	
24a. REC'D BY REGISTRAR <u>Aug 5 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. B. Beach</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Pages 1 and 2 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

9148

CERTIFICATE OF DEATH

09138

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Joppa (Rural)		c. LENGTH OF STAY IN 1b 1 week	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mountain Road		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Charlestown (Rural) 07X-2	
3. NAME OF DECEASED (Type or print) Georgia First Edith Middle Shinault Last		4. DATE OF DEATH August Month 20 Day 1958 Year 19	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH March 15, 1905
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nursing Assistant		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government	11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME David Franklin Cornett	
14. MOTHER'S MAIDEN NAME Orlena ---		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. NONE		17. INFORMANT Mrs. Ruby Privett, Box 439 R.D. 1 Mountain Rd. Joppa, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCT 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY OCCLUSION DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 WEEKS "	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7-2, 1958, to 8-20, 1958, that I last saw the deceased alive on 8/4, 1958, and that death occurred at 3:00 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Gunther D. Hirsch</i> M.D.		ADDRESS (Street, city or town, state) 421 CONGRESS AVE DATE SIGNED	
PHYSICIAN'S NAME (Type) GUNTHER D. HIRSCH		HAIRE DE PRACE Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8-24, 1958	22c. NAME OF CEMETERY OR CREMATORY Principio Methodist Cem.	22d. LOCATION (City, town, or county) (State) Principio, Cecil Co. Md.
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph R. Brant</i> ADDRESS North East, Maryland		24a. REC'D BY REGISTRAR DATE AUG 25 '58 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hirsch</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it is to be completely filled in by the funeral director. Page 3 should be detached and used for use as the burial-transit permit. Then please remove cards, papers, Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

M

71

1

MEDICAL CERTIFICATION

2

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9127 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09139

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hartford de Grace</u> 6 hrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Joppo</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hartford Memorial Hosp</u>		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>W. H. 2m Henry Smothers</u>		4. DATE OF DEATH Month Day Year <u>August 16 1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 17, 1934</u>
9. AGE (In years last birthday) <u>23</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Contractor</u>	
11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Charles E. Smothers</u>		14. MOTHER'S MAIDEN NAME <u>Mary Banks</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mr. Charles E. Smothers - Bel-Air, Md.</u>		Address <u>Churchville Road</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage from Left Pulmonary Vein</u> 982X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Puncture pericardium</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Struck in fight</u>	
20c. TIME OF INJURY Month, Day, Year <u>8-15-58</u> Hour <u>10</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Bel Air Hartford Md.</u>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Naturol causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>8-16-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 20, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Clarks Chapel Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Bel Air Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur J Bullock, Harro de Grace, Md.</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Hanna</u>	
ADDRESS <u>Hartford de Grace, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	
DATE <u>AUG 20 '58</u>			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15
2107 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT

NAME OF DECEASED
RESIDENCE
DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
MANNER OF DEATH
DISEASE OR INJURY
MEDICAL HISTORY
FAMILY HISTORY
SOCIAL HISTORY
HISTORICAL DATA
PHYSICAL EXAMINATION
LABORATORY EXAMINATIONS
POSTMORTEM EXAMINATION
FINDINGS
CONCLUSIONS
SIGNATURE OF EXAMINER
DATE OF SIGNATURE

NAME OF DECEASED		RESIDENCE	
DATE OF DEATH		PLACE OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH	
DISEASE OR INJURY		MEDICAL HISTORY	
FAMILY HISTORY		SOCIAL HISTORY	
HISTORICAL DATA		PHYSICAL EXAMINATION	
LABORATORY EXAMINATIONS		POSTMORTEM EXAMINATION	
FINDINGS		CONCLUSIONS	
SIGNATURE OF EXAMINER		DATE OF SIGNATURE	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09140

Reg. Dist. No.

9149

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Harrison</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>3V01-4</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Monkton</u>		c. LENGTH OF STAY IN 1b <u>1 hour</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wilms Farm</u>		d. STREET ADDRESS <u>1210 Madison Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Andrew S. Southerland</u>		DATE OF DEATH <u>Aug 23, 1958</u>	
5. SEX <u>M</u>		6. COLOR OR RACE <u>C</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 14, 1905</u>	
9. AGE (In years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Penn R.R.</u>	
11. BIRTHPLACE (State or foreign country) <u>M.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Southerland</u>		14. MOTHER'S MAIDEN NAME <u>Winifred Southerland</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>1013 W. Pennvale St</u>	
17. INFORMANT <u>Winifred Southerland</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GSW Cerebrum</u> <u>9/19.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>9/19.5</u> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Ground hog hunting, rifle discharged accidentally</u>	
20c. TIME OF INJURY Month, Day, Year <u>8-23-58</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <u>Wilms Farm</u>		20f. (City or town) <u>Monkton</u> (County) <u>MD</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>8-23-58</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer-MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-26-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Wint Auburn</u>		22d. LOCATION (City, town, or county) <u>MD</u> (State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Geo. H. Nelson</u>		24a. REC'D BY REGISTRAR <u>Aug 26 '58</u>	
ADDRESS <u>1348 N. Calhoun St</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kram</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

206: From Med. Exam.'s Office 10/15/58
P.S.

9128

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Harford</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md.</i> b. COUNTY <i>Harford</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harre de Grace</i>				c. LENGTH OF STAY IN b. <i>40 hrs</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Harford Memorial Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Karen</i> Middle <i>Frederica</i> Last <i>Stinson</i>				4. DATE OF DEATH Month <i>Aug.</i> Day <i>30</i> Year <i>1958</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>Colored</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Aug. 28, 1958</i>	
9. AGE (In years last birthday) yrs. <i>1</i>		IF UNDER 1 YEAR Months <i>1</i> Days <i>16</i> Hours <i>16</i> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>			
13. FATHER'S NAME <i>McKinley Stinson</i>				14. MOTHER'S MAIDEN NAME <i>Anna Joan Buchanan</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <i>Mother</i>		Address <i>Same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Intracranial Hemorrhage</i> <i>760.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Aug. 28</i> , 1958, to <i>Aug. 30</i> , 1958, that I last saw the deceased alive on <i>Aug. 30</i> , 1958, and that death occurred at <i>8:00 A.M.</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <i>George T. Stansbury, M.D. 569 Revolution St., Harre de Grace, Md. 8/30/58</i>							
ACTUAL SIGNATURE <i>George T. Stansbury</i>		PHYSICIAN'S NAME (Type) <i>George T. Stansbury</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>8-31-58</i>		22c. NAME OF CEMETERY OR CREMATORY <i>St. James Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Harre de Grace Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Charles J. Bullock</i> ADDRESS <i>Harre de Grace, Md.</i>				24a. REC'D BY REGISTRAR DATE <i>SEP 3 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Knapp</i>	

2071321XV5

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and is completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1016

CERTIFICATE OF DEATH

3128

PLACE IN BOX		DATE OF DEATH	
1. NAME OF DECEASED		2. SEX	
3. AGE		4. RACE	
5. OCCUPATION		6. CAUSE OF DEATH	
7. PLACE OF DEATH		8. TIME OF DEATH	
9. SIGNATURE OF DECEASED		10. SIGNATURE OF WITNESS	
11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF CORONER	
13. SIGNATURE OF JUDGE		14. SIGNATURE OF CLERK	
15. SIGNATURE OF REGISTRAR		16. SIGNATURE OF DEPUTY REGISTRAR	
17. SIGNATURE OF ASSISTANT REGISTRAR		18. SIGNATURE OF CLERK	
19. SIGNATURE OF DEPUTY CLERK		20. SIGNATURE OF ASSISTANT CLERK	
21. SIGNATURE OF DEPUTY ASSISTANT CLERK		22. SIGNATURE OF DEPUTY DEPUTY ASSISTANT CLERK	
23. SIGNATURE OF DEPUTY DEPUTY ASSISTANT CLERK		24. SIGNATURE OF DEPUTY DEPUTY ASSISTANT CLERK	
25. SIGNATURE OF DEPUTY DEPUTY ASSISTANT CLERK		26. SIGNATURE OF DEPUTY DEPUTY ASSISTANT CLERK	
27. SIGNATURE OF DEPUTY DEPUTY ASSISTANT CLERK		28. SIGNATURE OF DEPUTY DEPUTY ASSISTANT CLERK	
29. SIGNATURE OF DEPUTY DEPUTY ASSISTANT CLERK		30. SIGNATURE OF DEPUTY DEPUTY ASSISTANT CLERK	
31. SIGNATURE OF DEPUTY DEPUTY ASSISTANT CLERK		32. SIGNATURE OF DEPUTY DEPUTY ASSISTANT CLERK	
33. SIGNATURE OF DEPUTY DEPUTY ASSISTANT CLERK		34. SIGNATURE OF DEPUTY DEPUTY ASSISTANT CLERK	
35. SIGNATURE OF DEPUTY DEPUTY ASSISTANT CLERK		36. SIGNATURE OF DEPUTY DEPUTY ASSISTANT CLERK	
37. SIGNATURE OF DEPUTY DEPUTY ASSISTANT CLERK		38. SIGNATURE OF DEPUTY DEPUTY ASSISTANT CLERK	
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RECEIVED
BALTIMORE, MD
JAN 10 1916
DEPARTMENT OF HEALTH
OFFICE OF THE REGISTRAR
100 N. CALVERT ST.
BALTIMORE, MD

9129

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Hartford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Hartford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>				c. LENGTH OF STAY IN 1b <u>16 hrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hartford Mem. Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. STREET ADDRESS <u>Rock Spring Rd.</u>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Janice Alleyra Terrell</u>				4. DATE OF DEATH Month Day Year <u>August 7 19 58</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 22, 1958</u>	9. AGE (In years lost birthday) yrs. <u>14</u>	IF UNDER 1 YEAR Months Days Hours Min. <u>14</u>	IF UNDER 24 HRS. <u>14</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Henry Presbury</u>				14. MOTHER'S MAIDEN NAME <u>Helen Terrell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Helen Terrell Forest Rock Spring Rd, H-11, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral Lobar Pneumonia</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>7630</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Dehydration</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Aug. 6</u> , 19 <u>58</u> , to <u>Aug. 7</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Aug. 7</u> , 19 <u>58</u> , and that death occurred at <u>6:30 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Erlinda L. Marbella</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>413 Revolution St. HARRE DE GRACE, MD.</u>			
PHYSICIAN'S NAME (Type) <u>ERLINDA L. MARBELLA, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 8, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. James G.M.E. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Harre de Grace, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Atkins Bullock - Harre de Grace Md.</u>				24a. REC'D BY REGISTRAR <u>Atkins Bullock</u>		24b. REGISTRAR'S SIGNATURE <u>Atkins Bullock</u>	
				DATE <u>AUG 11 '58</u>			

2071203XV4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9130

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace		c. LENGTH OF STAY IN 1b 3 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Nina Middle Bell Last Vesely		4. DATE OF DEATH Month August Day 16 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 28 Feb. 1904
9. AGE (In years lost birthday) yrs. 54		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-wife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA.			
13. FATHER'S NAME John Homer		14. MOTHER'S MAIDEN NAME Ida Bell Singleton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Joseph W. Vesely		Address R.D. #1 Aberdeen, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 581.0 Cerebro Vascular Accident. DUE TO (b) Cirrhosis of The Liver Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)			INTERVAL BETWEEN ONSET AND DEATH 24 month
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 002x Pulmonary Tuberculosis			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from: July 15, 1958 , to August 16, 1958 , that I last saw the deceased alive on Aug. 16, 1958 , and that death occurred at 7:15pm , from the causes and on the date stated above.			
ACTUAL SIGNATURE Andre Weiss		ADDRESS (Street, city or town, state) 17 N. Phila. Blvd. DATE SIGNED 8/18/58	
PHYSICIAN'S NAME (Type) Andre Weiss M.D.		Aberdeen, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/19/58	22c. NAME OF CEMETERY OR CREMATORY Bakers Cemetery	22d. LOCATION (City, town, or county) (State) R.D., Aberdeen, Md.
23. FUNERAL DIRECTOR'S SIGNATURE John G. Harring		ADDRESS Aberdeen, Md.	24a. RECORDING REGISTRAR August 21 1958
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. Name of deceased
 2. Date of death
 3. Place of death
 4. Cause of death
 5. Signature of physician
 6. Signature of registrar
 7. Date of registration

CERTIFICATE OF DEATH

1911

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

1. NAME OF DECEASED JAMES H. HARRIS		2. DATE OF DEATH JAN 15 1911	
3. PLACE OF DEATH HOME		4. CAUSE OF DEATH HEART DISEASE	
5. SIGNATURE OF PHYSICIAN J. H. HARRIS		6. SIGNATURE OF REGISTRAR J. H. HARRIS	
7. DATE OF REGISTRATION JAN 15 1911		8. PLACE OF REGISTRATION BALTIMORE	
9. NAME OF DECEASED JAMES H. HARRIS		10. DATE OF DEATH JAN 15 1911	
11. PLACE OF DEATH HOME		12. CAUSE OF DEATH HEART DISEASE	
13. SIGNATURE OF PHYSICIAN J. H. HARRIS		14. SIGNATURE OF REGISTRAR J. H. HARRIS	
15. DATE OF REGISTRATION JAN 15 1911		16. PLACE OF REGISTRATION BALTIMORE	
17. NAME OF DECEASED JAMES H. HARRIS		18. DATE OF DEATH JAN 15 1911	
19. PLACE OF DEATH HOME		20. CAUSE OF DEATH HEART DISEASE	
21. SIGNATURE OF PHYSICIAN J. H. HARRIS		22. SIGNATURE OF REGISTRAR J. H. HARRIS	
23. DATE OF REGISTRATION JAN 15 1911		24. PLACE OF REGISTRATION BALTIMORE	
25. NAME OF DECEASED JAMES H. HARRIS		26. DATE OF DEATH JAN 15 1911	
27. PLACE OF DEATH HOME		28. CAUSE OF DEATH HEART DISEASE	
29. SIGNATURE OF PHYSICIAN J. H. HARRIS		30. SIGNATURE OF REGISTRAR J. H. HARRIS	
31. DATE OF REGISTRATION JAN 15 1911		32. PLACE OF REGISTRATION BALTIMORE	
33. NAME OF DECEASED JAMES H. HARRIS		34. DATE OF DEATH JAN 15 1911	
35. PLACE OF DEATH HOME		36. CAUSE OF DEATH HEART DISEASE	
37. SIGNATURE OF PHYSICIAN J. H. HARRIS		38. SIGNATURE OF REGISTRAR J. H. HARRIS	
39. DATE OF REGISTRATION JAN 15 1911		40. PLACE OF REGISTRATION BALTIMORE	
41. NAME OF DECEASED JAMES H. HARRIS		42. DATE OF DEATH JAN 15 1911	
43. PLACE OF DEATH HOME		44. CAUSE OF DEATH HEART DISEASE	
45. SIGNATURE OF PHYSICIAN J. H. HARRIS		46. SIGNATURE OF REGISTRAR J. H. HARRIS	
47. DATE OF REGISTRATION JAN 15 1911		48. PLACE OF REGISTRATION BALTIMORE	
49. NAME OF DECEASED JAMES H. HARRIS		50. DATE OF DEATH JAN 15 1911	
51. PLACE OF DEATH HOME		52. CAUSE OF DEATH HEART DISEASE	
53. SIGNATURE OF PHYSICIAN J. H. HARRIS		54. SIGNATURE OF REGISTRAR J. H. HARRIS	
55. DATE OF REGISTRATION JAN 15 1911		56. PLACE OF REGISTRATION BALTIMORE	
57. NAME OF DECEASED JAMES H. HARRIS		58. DATE OF DEATH JAN 15 1911	
59. PLACE OF DEATH HOME		60. CAUSE OF DEATH HEART DISEASE	
61. SIGNATURE OF PHYSICIAN J. H. HARRIS		62. SIGNATURE OF REGISTRAR J. H. HARRIS	
63. DATE OF REGISTRATION JAN 15 1911		64. PLACE OF REGISTRATION BALTIMORE	
65. NAME OF DECEASED JAMES H. HARRIS		66. DATE OF DEATH JAN 15 1911	
67. PLACE OF DEATH HOME		68. CAUSE OF DEATH HEART DISEASE	
69. SIGNATURE OF PHYSICIAN J. H. HARRIS		70. SIGNATURE OF REGISTRAR J. H. HARRIS	
71. DATE OF REGISTRATION JAN 15 1911		72. PLACE OF REGISTRATION BALTIMORE	
73. NAME OF DECEASED JAMES H. HARRIS		74. DATE OF DEATH JAN 15 1911	
75. PLACE OF DEATH HOME		76. CAUSE OF DEATH HEART DISEASE	
77. SIGNATURE OF PHYSICIAN J. H. HARRIS		78. SIGNATURE OF REGISTRAR J. H. HARRIS	
79. DATE OF REGISTRATION JAN 15 1911		80. PLACE OF REGISTRATION BALTIMORE	
81. NAME OF DECEASED JAMES H. HARRIS		82. DATE OF DEATH JAN 15 1911	
83. PLACE OF DEATH HOME		84. CAUSE OF DEATH HEART DISEASE	
85. SIGNATURE OF PHYSICIAN J. H. HARRIS		86. SIGNATURE OF REGISTRAR J. H. HARRIS	
87. DATE OF REGISTRATION JAN 15 1911		88. PLACE OF REGISTRATION BALTIMORE	
89. NAME OF DECEASED JAMES H. HARRIS		90. DATE OF DEATH JAN 15 1911	
91. PLACE OF DEATH HOME		92. CAUSE OF DEATH HEART DISEASE	
93. SIGNATURE OF PHYSICIAN J. H. HARRIS		94. SIGNATURE OF REGISTRAR J. H. HARRIS	
95. DATE OF REGISTRATION JAN 15 1911		96. PLACE OF REGISTRATION BALTIMORE	
97. NAME OF DECEASED JAMES H. HARRIS		98. DATE OF DEATH JAN 15 1911	
99. PLACE OF DEATH HOME		100. CAUSE OF DEATH HEART DISEASE	
101. SIGNATURE OF PHYSICIAN J. H. HARRIS		102. SIGNATURE OF REGISTRAR J. H. HARRIS	
103. DATE OF REGISTRATION JAN 15 1911		104. PLACE OF REGISTRATION BALTIMORE	
105. NAME OF DECEASED JAMES H. HARRIS		106. DATE OF DEATH JAN 15 1911	
107. PLACE OF DEATH HOME		108. CAUSE OF DEATH HEART DISEASE	
109. SIGNATURE OF PHYSICIAN J. H. HARRIS		110. SIGNATURE OF REGISTRAR J. H. HARRIS	
111. DATE OF REGISTRATION JAN 15 1911		112. PLACE OF REGISTRATION BALTIMORE	
113. NAME OF DECEASED JAMES H. HARRIS		114. DATE OF DEATH JAN 15 1911	
115. PLACE OF DEATH HOME		116. CAUSE OF DEATH HEART DISEASE	
117. SIGNATURE OF PHYSICIAN J. H. HARRIS		118. SIGNATURE OF REGISTRAR J. H. HARRIS	
119. DATE OF REGISTRATION JAN 15 1911		120. PLACE OF REGISTRATION BALTIMORE	
121. NAME OF DECEASED JAMES H. HARRIS		122. DATE OF DEATH JAN 15 1911	
123. PLACE OF DEATH HOME		124. CAUSE OF DEATH HEART DISEASE	
125. SIGNATURE OF PHYSICIAN J. H. HARRIS		126. SIGNATURE OF REGISTRAR J. H. HARRIS	
127. DATE OF REGISTRATION JAN 15 1911		128. PLACE OF REGISTRATION BALTIMORE	
129. NAME OF DECEASED JAMES H. HARRIS		130. DATE OF DEATH JAN 15 1911	
131. PLACE OF DEATH HOME		132. CAUSE OF DEATH HEART DISEASE	
133. SIGNATURE OF PHYSICIAN J. H. HARRIS		134. SIGNATURE OF REGISTRAR J. H. HARRIS	
135. DATE OF REGISTRATION JAN 15 1911		136. PLACE OF REGISTRATION BALTIMORE	
137. NAME OF DECEASED JAMES H. HARRIS		138. DATE OF DEATH JAN 15 1911	
139. PLACE OF DEATH HOME		140. CAUSE OF DEATH HEART DISEASE	
141. SIGNATURE OF PHYSICIAN J. H. HARRIS		142. SIGNATURE OF REGISTRAR J. H. HARRIS	
143. DATE OF REGISTRATION JAN 15 1911		144. PLACE OF REGISTRATION BALTIMORE	
145. NAME OF DECEASED JAMES H. HARRIS		146. DATE OF DEATH JAN 15 1911	
147. PLACE OF DEATH HOME		148. CAUSE OF DEATH HEART DISEASE	
149. SIGNATURE OF PHYSICIAN J. H. HARRIS		150. SIGNATURE OF REGISTRAR J. H. HARRIS	
151. DATE OF REGISTRATION JAN 15 1911		152. PLACE OF REGISTRATION BALTIMORE	
153. NAME OF DECEASED JAMES H. HARRIS		154. DATE OF DEATH JAN 15 1911	
155. PLACE OF DEATH HOME		156. CAUSE OF DEATH HEART DISEASE	
157. SIGNATURE OF PHYSICIAN J. H. HARRIS		158. SIGNATURE OF REGISTRAR J. H. HARRIS	
159. DATE OF REGISTRATION JAN 15 1911		160. PLACE OF REGISTRATION BALTIMORE	
161. NAME OF DECEASED JAMES H. HARRIS		162. DATE OF DEATH JAN 15 1911	
163. PLACE OF DEATH HOME		164. CAUSE OF DEATH HEART DISEASE	
165. SIGNATURE OF PHYSICIAN J. H. HARRIS		166. SIGNATURE OF REGISTRAR J. H. HARRIS	
167. DATE OF REGISTRATION JAN 15 1911		168. PLACE OF REGISTRATION BALTIMORE	
169. NAME OF DECEASED JAMES H. HARRIS		170. DATE OF DEATH JAN 15 1911	
171. PLACE OF DEATH HOME		172. CAUSE OF DEATH HEART DISEASE	
173. SIGNATURE OF PHYSICIAN J. H. HARRIS		174. SIGNATURE OF REGISTRAR J. H. HARRIS	
175. DATE OF REGISTRATION JAN 15 1911		176. PLACE OF REGISTRATION BALTIMORE	
177. NAME OF DECEASED JAMES H. HARRIS		178. DATE OF DEATH JAN 15 1911	
179. PLACE OF DEATH HOME		180. CAUSE OF DEATH HEART DISEASE	
181. SIGNATURE OF PHYSICIAN J. H. HARRIS		182. SIGNATURE OF REGISTRAR J. H. HARRIS	
183. DATE OF REGISTRATION JAN 15 1911		184. PLACE OF REGISTRATION BALTIMORE	
185. NAME OF DECEASED JAMES H. HARRIS		186. DATE OF DEATH JAN 15 1911	
187. PLACE OF DEATH HOME		188. CAUSE OF DEATH HEART DISEASE	
189. SIGNATURE OF PHYSICIAN J. H. HARRIS		190. SIGNATURE OF REGISTRAR J. H. HARRIS	
191. DATE OF REGISTRATION JAN 15 1911		192. PLACE OF REGISTRATION BALTIMORE	
193. NAME OF DECEASED JAMES H. HARRIS		194. DATE OF DEATH JAN 15 1911	
195. PLACE OF DEATH HOME		196. CAUSE OF DEATH HEART DISEASE	
197. SIGNATURE OF PHYSICIAN J. H. HARRIS		198. SIGNATURE OF REGISTRAR J. H. HARRIS	
199. DATE OF REGISTRATION JAN 15 1911		200. PLACE OF REGISTRATION BALTIMORE	

9132

CERTIFICATE OF DEATH

09145

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de grace</u>				c. LENGTH OF STAY IN 1b <u>32</u> <u>Bel Air</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Harford Memorial Hosp</u>				d. STREET ADDRESS <u>625 Roland</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Louis</u> First <u>Joseph</u> Middle <u>Waldenberger</u> Last				4. DATE OF DEATH <u>August</u> Month <u>4</u> Day <u>19</u> Year <u>58</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/23/06</u>	9. AGE (In years lost birthday) <u>51</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>County Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Highway Construction</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Louis Joseph Waldenberger</u>				14. MOTHER'S MAIDEN NAME <u>Alice McKethrick</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>WW II</u>		16. SOCIAL SECURITY NO. <u>212-10-7513</u>		17. INFORMANT <u>Frances Waldenberger -</u> Address <u>Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Infarction</u> <u>422.1</u> DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardiac Decompensation</u> DUE TO (c) <u>Arteriosclerotic Cardiovascular Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cholelithiasis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>about 1 wk.</u> <u>3-4 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 18th</u> , 19 <u>58</u> , to <u>Aug 4th</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Aug 4th</u> , 19 <u>58</u> , and that death occurred at <u>4:10 AM</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edward C. Loo, M.D.</u>				ADDRESS (Street, city or town, state) <u>211 N. Union Ave</u> DATE SIGNED <u>Aug 4th</u>			
PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u>				<u>Harre de Grace, Ind.</u> 19 <u>58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>August 6, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>		22d. LOCATION (City, town, or county) (State) <u>Bel Air, Harford County, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph W. Foster</u>				ADDRESS <u>W. Broadway and Williams St.</u> <u>Bel Air, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 5 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Alfred Smith</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician or completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9133

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY HARFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAURE DE GRACE		c. LENGTH OF STAY IN 1b 2 HRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD Memorial Hosp.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X ABERDEEN RURAL	
3. NAME OF DECEASED (Type or print) Robert B Wall		4. DATE OF DEATH August 26 1958	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/2/1898
9. AGE (in years last birthday) 60		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or retired) Assemblyman A.P.C.		10b. KIND OF BUSINESS OR INDUSTRY Govt.	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME MACK WALL		14. MOTHER'S MAIDEN NAME Floy Miller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes War #1		16. SOCIAL SECURITY NO. -	
17. INFORMANT Mrs. Robt. B Wall		Address Aberdeen #1-1450	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterial Hypertension ("Essential") DUE TO (c) 5 yr.		INTERVAL BETWEEN ONSET AND DEATH 4 hr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Asthma, pulmonary emphysema			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1955 , 19 8-26-1958 , that I last saw the deceased alive on 8/26/58 , and that death occurred at 3:15 M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Peter P. Rodman		DATE SIGNED 8/26/58	
PHYSICIAN'S NAME (Type) Peter P. Rodman		ADDRESS (Street, city or town, state) 8 Law St., Aberdeen, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/28/1958, Oak Grove Baptist	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) Bel Air R.G. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John G. Sarrug		24a. REC'D BY REGISTRAR DATE AUG 28 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9150

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION US Army Hospital, Aberdeen Proving Ground, Md		d. STREET ADDRESS 1 Rigdon Road	
3. NAME OF DECEASED (Type or print) First Thomas Middle Joseph Last Walsh		4. DATE OF DEATH Month August Day 27 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9 Jan 1879
9. AGE (In years last birthday) yrs. 79		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Army M Sgt		10b. KIND OF BUSINESS OR INDUSTRY Army	
11. BIRTHPLACE (State or foreign country) Ireland		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Patrick Walsh		14. MOTHER'S MAIDEN NAME Mary (Unknown) Kelly	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Mrs Mary Walsh (wife)		Address 1 Rigdon Road Aberdeen, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured Abdominal Aneurysm (Aorta) 451X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis, Aorta DUE TO (c) Arteriosclerosis, General			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from August 27 , 19 58 , to August 27 , 19 58 , that I last saw the deceased alive on August 27 , 19 58 , and that death occurred at 6:15 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED US Army Hospital Aberdeen PG Md 27 Aug 58			
ACTUAL SIGNATURE Joseph N. Silverstein		M.D. US Army Hospital Aberdeen PG Md	
PHYSICIAN'S NAME (Type) JOSEPH N SILVERSTEIN Capt MC			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/31/58	22c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens	22d. LOCATION (City, town, or county) (State) Bel Air Maryland
23. FUNERAL DIRECTOR'S SIGNATURE John G. Harving		ADDRESS Aberdeen Md	
24a. REC'D BY REGISTRAR DATE SEP 2 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Hanna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and is completely filled in by the funeral director, page 3 should be detached and use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DE-14-02-A

Everett Cemetery

WILLIAM BOND

WILLIAM BOND

1920

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Name of Deceased		Date of Death	
William Bond		1920	
Age		Sex	
100		Male	
Race		Color	
White		White	
Place of Birth		Date of Birth	
Maryland		1820	
Usual Residence		Cause of Death	
Baltimore, Md.		Heart Disease	
Occupation		Duration of Illness	
None		10 Days	
Signature of Physician		Signature of Registrar	
[Signature]		[Signature]	
Date of Certificate		Place of Death	
1920		Baltimore, Md.	

9151

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Street				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Street			
d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Frank Middle Smith Last Webb				4. DATE OF DEATH Month Aug. Day 13 , 1958 Year 19			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 17, 1871	9. AGE (In years last birthday) 87 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) York Co., Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph H. Webb				14. MOTHER'S MAIDEN NAME Salome M. Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Mary Webb, Street Rd., Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio Sclerotic C-V Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH instant
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from Jan , 1958, to Aug 13 , 1958, that I last saw the deceased alive on Aug 13 , 1958, and that death occurred at 9:45 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Joseph A. Hunt M.D.				ADDRESS (Street, city or town, state) Delta, Pa.			
PHYSICIAN'S NAME (Type) Joseph A. Hunt 1912				DATE SIGNED 8/14/58			
22a. BURIAL, CREMATION, or other disposition (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		8-16-58		Fawn Grove Meth.		Fawn Grove, York Co., Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth W. Cashman				ADDRESS Stewartstown, Pa.		24a. REC'D BY REGISTRAR DATE AUG 18 1958	
				24b. REGISTRAR'S SIGNATURE Cashman & Hunt			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9134

CERTIFICATE OF DEATH

Reg. Dist. No.

09149

1. PLACE OF DEATH o. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY HARFORD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAURE DE GRACE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAURE DE GRACE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL HOSP.				1 d. STREET ADDRESS 130 Wilson			
3. NAME OF DECEASED (Type or print) First Gregg Middle Williams Last Williams				4. DATE OF DEATH Month August Day 5 Year 1958			
5. SEX MALE		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug 4, 1958	
9. AGE (In years lost birthday) yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NEWBORN Infant				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME ROGER E. Williams				14. MOTHER'S MAIDEN NAME Naomi Arlene Schaffhayer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cyanotic congenital heart disease 754.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Miliary atelectasis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 30 hrs 30 hrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While o. m. Not while o. m. of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/5 , 19 58 , to 8/5 , 19 58 , that I last saw the deceased alive on 8/5 , 19 58 , and that death occurred at 10:35 M, from the causes and on the date stated above. P ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Theodore H. Gauer M.D.							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		8/6/58		Mt. Eun		Harford County, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. H. Pn				24a. REC'D BY REGISTRAR W. H. Pn		24b. REGISTRAR'S SIGNATURE W. H. Pn	
DATE				DATE		DATE	
AUG 8 '58				AUG 8 '58		AUG 8 '58	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2071385XV6

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John A. Smith</i>		2. SEX <i>Male</i>		3. AGE <i>65</i>	
4. DATE OF DEATH <i>April 15, 1968</i>		5. TIME OF DEATH <i>10:15 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Myocardial Infarction</i>		8. MANNER OF DEATH <i>Natural</i>		9. MEDICAL HISTORY <i>None</i>	
10. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Jones</i>		11. SIGNATURE OF REGISTRAR <i>John A. Smith</i>		12. SIGNATURE OF WITNESS <i>John A. Smith</i>	
13. SIGNATURE OF DECEASED <i>John A. Smith</i>		14. SIGNATURE OF SURVIVOR <i>John A. Smith</i>		15. SIGNATURE OF NEXT OF KIN <i>John A. Smith</i>	
16. SIGNATURE OF BURIAL OFFICIAL <i>John A. Smith</i>		17. SIGNATURE OF FUNERAL HOME <i>John A. Smith</i>		18. SIGNATURE OF CEMETERY <i>John A. Smith</i>	
19. SIGNATURE OF CHURCH <i>John A. Smith</i>		20. SIGNATURE OF MINISTRY <i>John A. Smith</i>		21. SIGNATURE OF OTHER <i>John A. Smith</i>	
22. SIGNATURE OF OTHER <i>John A. Smith</i>		23. SIGNATURE OF OTHER <i>John A. Smith</i>		24. SIGNATURE OF OTHER <i>John A. Smith</i>	
25. SIGNATURE OF OTHER <i>John A. Smith</i>		26. SIGNATURE OF OTHER <i>John A. Smith</i>		27. SIGNATURE OF OTHER <i>John A. Smith</i>	
28. SIGNATURE OF OTHER <i>John A. Smith</i>		29. SIGNATURE OF OTHER <i>John A. Smith</i>		30. SIGNATURE OF OTHER <i>John A. Smith</i>	
31. SIGNATURE OF OTHER <i>John A. Smith</i>		32. SIGNATURE OF OTHER <i>John A. Smith</i>		33. SIGNATURE OF OTHER <i>John A. Smith</i>	
34. SIGNATURE OF OTHER <i>John A. Smith</i>		35. SIGNATURE OF OTHER <i>John A. Smith</i>		36. SIGNATURE OF OTHER <i>John A. Smith</i>	
37. SIGNATURE OF OTHER <i>John A. Smith</i>		38. SIGNATURE OF OTHER <i>John A. Smith</i>		39. SIGNATURE OF OTHER <i>John A. Smith</i>	
40. SIGNATURE OF OTHER <i>John A. Smith</i>		41. SIGNATURE OF OTHER <i>John A. Smith</i>		42. SIGNATURE OF OTHER <i>John A. Smith</i>	
43. SIGNATURE OF OTHER <i>John A. Smith</i>		44. SIGNATURE OF OTHER <i>John A. Smith</i>		45. SIGNATURE OF OTHER <i>John A. Smith</i>	
46. SIGNATURE OF OTHER <i>John A. Smith</i>		47. SIGNATURE OF OTHER <i>John A. Smith</i>		48. SIGNATURE OF OTHER <i>John A. Smith</i>	
49. SIGNATURE OF OTHER <i>John A. Smith</i>		50. SIGNATURE OF OTHER <i>John A. Smith</i>		51. SIGNATURE OF OTHER <i>John A. Smith</i>	
52. SIGNATURE OF OTHER <i>John A. Smith</i>		53. SIGNATURE OF OTHER <i>John A. Smith</i>		54. SIGNATURE OF OTHER <i>John A. Smith</i>	
55. SIGNATURE OF OTHER <i>John A. Smith</i>		56. SIGNATURE OF OTHER <i>John A. Smith</i>		57. SIGNATURE OF OTHER <i>John A. Smith</i>	
58. SIGNATURE OF OTHER <i>John A. Smith</i>		59. SIGNATURE OF OTHER <i>John A. Smith</i>		60. SIGNATURE OF OTHER <i>John A. Smith</i>	
61. SIGNATURE OF OTHER <i>John A. Smith</i>		62. SIGNATURE OF OTHER <i>John A. Smith</i>		63. SIGNATURE OF OTHER <i>John A. Smith</i>	
64. SIGNATURE OF OTHER <i>John A. Smith</i>		65. SIGNATURE OF OTHER <i>John A. Smith</i>		66. SIGNATURE OF OTHER <i>John A. Smith</i>	
67. SIGNATURE OF OTHER <i>John A. Smith</i>		68. SIGNATURE OF OTHER <i>John A. Smith</i>		69. SIGNATURE OF OTHER <i>John A. Smith</i>	
70. SIGNATURE OF OTHER <i>John A. Smith</i>		71. SIGNATURE OF OTHER <i>John A. Smith</i>		72. SIGNATURE OF OTHER <i>John A. Smith</i>	
73. SIGNATURE OF OTHER <i>John A. Smith</i>		74. SIGNATURE OF OTHER <i>John A. Smith</i>		75. SIGNATURE OF OTHER <i>John A. Smith</i>	
76. SIGNATURE OF OTHER <i>John A. Smith</i>		77. SIGNATURE OF OTHER <i>John A. Smith</i>		78. SIGNATURE OF OTHER <i>John A. Smith</i>	
79. SIGNATURE OF OTHER <i>John A. Smith</i>		80. SIGNATURE OF OTHER <i>John A. Smith</i>		81. SIGNATURE OF OTHER <i>John A. Smith</i>	
82. SIGNATURE OF OTHER <i>John A. Smith</i>		83. SIGNATURE OF OTHER <i>John A. Smith</i>		84. SIGNATURE OF OTHER <i>John A. Smith</i>	
85. SIGNATURE OF OTHER <i>John A. Smith</i>		86. SIGNATURE OF OTHER <i>John A. Smith</i>		87. SIGNATURE OF OTHER <i>John A. Smith</i>	
88. SIGNATURE OF OTHER <i>John A. Smith</i>		89. SIGNATURE OF OTHER <i>John A. Smith</i>		90. SIGNATURE OF OTHER <i>John A. Smith</i>	
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1. NAME OF DECEASED
2. SEX
3. AGE
4. DATE OF DEATH
5. TIME OF DEATH
6. PLACE OF DEATH
7. CAUSE OF DEATH
8. MANNER OF DEATH
9. MEDICAL HISTORY
10. SIGNATURE OF PHYSICIAN
11. SIGNATURE OF REGISTRAR
12. SIGNATURE OF WITNESS
13. SIGNATURE OF DECEASED
14. SIGNATURE OF SURVIVOR
15. SIGNATURE OF NEXT OF KIN
16. SIGNATURE OF BURIAL OFFICIAL
17. SIGNATURE OF FUNERAL HOME
18. SIGNATURE OF CEMETERY
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9135

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harrode Grace</i>		c. LENGTH OF STAY in 1b <i>30 minutes</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Harford Memorial Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Mary Jane Willis</i>		4. DATE OF DEATH <i>August 18 1958</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 28, 1953</i>
9. AGE (In years last birthday) <i>5</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	
11. BIRTHPLACE (State or foreign country) <i>Harford Co, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U S A</i>	
13. FATHER'S NAME <i>Frank H. Willis</i>		14. MOTHER'S MAIDEN NAME <i>Viola Catron</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>no</i>	
17. INFORMANT <i>Mrs. Viola Willis</i>		Address <i>Harrode Grace Md. R. 10.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Fracture Cervical vertebra</i> DUE TO (b) <i>810X</i> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. <i>Hawthorne</i> DUE TO (c) <i>Md. R. 10.</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Fracture R femur</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Auto accident, auto-train type</i>	
20c. TIME OF INJURY Month, Day, Year <i>8-18-58</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home RR</i>		20f. (City or town) <i>Aberdeen</i> (County) <i>Harford</i> (State) <i>md</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Lorall C Palmer</i> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <i>Bel Air md</i> DATE SIGNED <i>8-18-58</i>	
EXAMINER'S NAME (Type) <i>Gerald C Palmer M.D.</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL OR CREMATION <i>Burial</i>		22b. DATE THEREOF <i>Aug. 21, 1958</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Baptist View</i>		22d. LOCATION (City, town, or county) <i>Harford Co, md.</i> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. S. Bailey</i> ADDRESS <i>Wilmington Md</i>		24a. REC'D BY REGISTRAR <i>AUG 25 '58</i> DATE	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kress</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

